Case Number:	CM13-0066797		
Date Assigned:	01/03/2014	**Date of Injury:**	12/02/2011
Decision Date:	03/19/2014	**UR Denial Date:**	11/26/2013
Priority:	Standard	**Application Received:**	12/17/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is an 83 year old male security officer who sustained a work-related injury to the neck and lower back on 12/2/11. The mechanism of injury was tripping and falling on a concrete slab; the patient struck the left side of his head, left shoulder, neck and low back. Prior treatment included ineffective trigger point injections, medications, and physical therapy to the cervical spine, lumbosacral spine, and the left shoulder. An operative report dated 7/26/12 noted that the patient underwent arthroscopic subacromial decompression, arthroscopic debridement of partial bursal side of the rotator cuff tear, and open distal clavicle resection with no complications. He recently completed 4-6 visits of chiropractic treatment and acupuncture treatment. An MRI of the left shoulder from 1/13/12 showed a large amount of fluid in the subacromial/subdeltoid bursa, most likely representing bursitis; marked tendinosis of the supraspinatus, with articular-sided fraying of the tendon near the distal insertion; moderate tendinosis of the infraspinatus and subscapularis tendons, with no tear appreciated; moderate to severe osteoarthritis of the acromioclavicular joint; an osteophyte created mild mass effect upon the myotendinous junction of the supraspinatus muscle; global degenerative tearing of the labrum; and a small amount of fluid adjacent to the conoid portion of the coracoclavicular ligament, consistent with prior tearing, likely remote. Additional marked thickening of the trapezoid portion of the coracoclavicular ligament also indicated prior trauma. There was no displacement of the distal clavicle relative to the acromion. CT of the head showed mild chronic small vessel ischemic change involving periventricular white matter; there was no acute intracranial bleed. CT of the cervical spine showed extensive degenerative changes without acute osseous abnormality. X-ray of the chest showed improvement in aeration of right lung base with continued elevation of right hemidiaphragm. MRI of the brain showed dilated ventricular system disproportionate to the degree of dilation of the surrounding cerebral sulci and polyp versus retention cyst within the

right maxillary sinus. There was no acute infarct. MRI of the lumbar spine showed suspected transitional lumbosacral anatomy with a rudimentary disc present at S1-S2. If surgery is planned, correlation with plain radiography was recommended. Moderate degenerative disc disease was present at L4-S1. There was mild central stenosis with moderate left and mild right foraminal stenosis at this level, otherwise, only mild degree of degenerative disc disease. A clinic note dated 11/6/13 indicates that the patient had some significant cervical neck pain, between a 6-8/10. The patient had acupuncture for the lower and mid back, which did help. There was notable numbness and paresthesias in patient's feet from the ankle downward. The patient stated that doing spine extensions while in bed gave some relief; however, turning in the bed caused a significant amount of pain. The patient had a significant amount of thoracic pain ranging from 6-10/10 whenever not utilizing pain medications. The pain was worse upon waking. Physical exam noted cervical spine tenderness into the left lower occipital region of the head and tenderness throughout the trapezial paraspinal cervical musculature. Range of motion was diminished in all axes, with extension and left axial rotation which provoked the same regular familiar left-sided lower neck pain. Upper extremities had manual motor of 5/5. Sensory was symmetrical and normal. There was thoracic spine tenderness. There was also significant pain upon flexion of the lower lumbar spine with limited range of motion, and lateral rotation with some pain upon extension as well, secondary to lumbar degenerative disc disease. There was no radiation down the lower extremities; however, there is notable decreased sensation of the bilateral feet from the ankle down. There was normal

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

six sessions of chiropractic care for the cervical/lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 154,Chronic Pain Treatment Guidelines Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: As per the California MTUS guidelines, the intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Guidelines recommend a trial of six visits over two weeks; with evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks may be recommended. As per the therapist follow up note dated 11/12/13, this patient has an improved pain level for the lower back; pain has decreased from 6-10/10 to 4-8/10. His neck pain also improved from 5-8/10 to 6/10. He had increased sensation and was less cold. His sleep and neck range of motion increased. He still had remaining deficits, including strength and endurance. Since there is documentation of functional improvement from the previous trial of chiropractic care, the request for six sessions of chiropractic treatment for the lumbar/cervical spine is certified.

six sessions of acupuncture for the cervical/lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: As per the California MTUS Acupuncture Medical Treatment Guidelines, acupuncture is an option when pain medication is reduced or not tolerated, and it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Guidelines further indicate that acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of mediation-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Acupuncture treatments may be extended if functional improvement is documented. A follow-up therapy note dated 11/12/13 did document improvement in pain level, neck range of motion, improved sleep and sensation, and no change with pain medications. The patient was still noted to have deficits remaining in strength and endurance. Therefore, the request for six sessions of acupuncture for cervical/lumbar spine is certified.